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GAO Audits

1. VETERANS' BENEFITS: Claims Processing Timeliness Performance Measures Could Be Improved (GAO-03-282), December 19, 2002

RESPONSIBLE ORGANIZATION: **Veterans Benefits Administration (VBA)**

RECOMMENDATIONS:

GAO recommended that the Secretary of Veterans Affairs direct the Under Secretary for Benefits to establish separate claims processing timeliness goals for its three main disability programs, incorporate these goals into VA's strategic plan and annual performance plans, and report its progress in meeting these goals in its annual performance reports.

ACTIONS TAKEN:

- The Department of Veterans Affairs (VA) concurred in principle with the recommendation. In July 2003, the Department issued its FY 2003-2008 Strategic Plan. The plan reflects service delivery performance measures for the average number of days to process rating-related actions for both Compensation and Pension Programs. While VBA has begun the process of identifying separate timeliness performance measures in the strategic plan, we anticipate complying with the GAO recommendation to report progress toward those goals beginning in FY 2005. VBA will continue to focus on achieving the timeliness goals established by the Secretary and will measure regional office performance improvements by the aggregate measure through FY 2004.

- The Department has adopted a new budget account structure that more closely links resources with results for each of VA's programs. The new account structure was presented for the first time with the 2004 Congressional budget by requesting mandatory and discretionary funding within each program, including compensation and pension. The full costs of administering and providing benefit payments for the compensation and pension programs are now reflected in our annual budget submission. This structure positions VBA to more readily

determine the full cost of each of our programs, shift resource debates from inputs to outcomes and results, and focus on planning and accountability. The implementation of this new account structure was the culmination of a multi-year project. The VA and the Office of Management and Budget jointly developed and implemented this new set of budget accounts and will continue to work closely together on this project. There is a slight revision to the FY 2005 budget account restructuring request. In order to clearly separate the discretionary funding from the mandatory funding, separate appropriation language is being requested for the administrative and entitlement portions of the budget. However, all costs are still being reported under each business line ensuring the full costs are properly reported for each program.

BUDGET IMPLICATIONS:

- None

2. VA HEALTH CARE: Improvements Needed in Hepatitis C Disease Management Practices (GAO-03-136), January 31, 2003

RESPONSIBLE ORGANIZATION: Veterans Health Administration (VHA)

RECOMMENDATIONS:

To continue to improve the management of hepatitis C, GAO recommended that the Secretary of Veterans Affairs direct the Under Secretary for Health to:

- Direct facilities to use special arrangements, such as mail or telephone when appropriate, to notify a veteran rather than waiting until the next regularly scheduled visit if more than 30 days away.

- Direct facilities to modify their computerized patient record systems so that providers are alerted to positive hepatitis C test results as soon as possible.

- Help facilities improve the timeliness of evaluations for veterans diagnosed with hepatitis C by encouraging facilities to use non-specialists to conduct initial evaluations and develop clinical guidelines for when to refer veterans to physician specialists for additional consultation.

ACTIONS TAKEN:

- Provided an Under Secretary's Information Letter to all facilities describing several options for using the electronic medical records system and local laboratory procedures to alert providers to positive hepatitis C test results (IL 10-2002-019).

- Provided data to facilities and VISN's through the External Peer Review Process regarding past and current performance in documenting patient notification of positive hepatitis C test results.

- Developed and tested the HealtheVet Information System which will allow veterans to have greater access to their own medical information, including laboratory test results through a secure, internet connection.

- Begun planning of pilot programs to test the use of automated telephone reminders to prompt patients to seek test results if not notified by their providers after two weeks.

- Created and implemented a Hepatitis C Case Registry, which permits local facilities to track all patients with positive tests or diagnoses for hepatitis C, to

ensure that appropriate follow-up, including notification and evaluation, proceeds in a timely manner.

- Conducted workshops, preceptorships, teleconferences, and conferences to increase the knowledge and skills of mid-level and non-specialist providers in the diagnosis, evaluation, and treatment of hepatitis C.

- Completed updated and revised Recommendations for Treatment of Patients with Chronic Hepatitis C, including guidance on initial evaluations, that can be performed by non-specialists.

BUDGET IMPLICATIONS:

- All of the actions described were undertaken using existing medical care and/or MAMOE resources. Healthe*e*Vet is a program developed and supported through the office of the Chief Information Officer.

3. VA LONG-TERM CARE: Service Gaps and Facility Restrictions Limit Veterans' Access to Non-institutional Care (GAO-03-487), May 9, 2003

RESPONSIBLE ORGANIZATION: Veterans Health Administration (VHA)

RECOMMENDATIONS:

To increase access to non-institutional long-term care services and make access more even across networks and facilities, GAO recommended that the Secretary of Veterans Affairs direct the Under Secretary for Health to:

- Ensure that facilities follow VA's eligibility standards when determining veteran eligibility for non-institutional long-term care services.

- Define and provide guidance on non-institutional respite care.

- Specify in VA policy whether home-based primary care, homemaker/home health aide, and skilled home heath care are to be available to all enrolled veterans.

- Refine current performance measures to help ensure that all VA facilities provide veterans with access to required non-institutional services.

ACTIONS TAKEN:

- Published IL 10-2003-012, "Non-Institutional Extended Care", that specified home-based primary care, homemaker/home health aide, and skilled home health care are to be available to all enrolled veterans. And provided guidance to the field regarding VA eligibility standards for non-institutional long-term care services.

- Published VHA Handbook 1140.2, "Respite Care", to define and provide guidance on respite care, including non-institutional respite care.

- Established a FY 2004 Network Performance Measure to increase access to the required non-institutional services.

BUDGET IMPLICATIONS:

- VA is increasing funding in 2004 and 2005 for non-institutional long-term care services.

4. FIREARMS CONTROLS: Federal Agencies Have Firearms Controls, but Could Strengthen Controls in Key Areas (GAO-03-688), June 13, 2003

RESPONSIBLE ORGANIZATION: **Assistant Secretary for Policy, Planning and Preparedness (PP&P)**
Veterans Health Administration (VHA)

RECOMMENDATION:

The Attorney General: The Secretaries of the Treasury, Interior, Veterans Affairs, and Postmaster General should:

- Periodically assess existing polices and procedures designated to control and safeguard firearms and determine whether they have been effective, or should be modified to help prevent future firearms losses. In assessing firearms controls, agencies should use as guides: (1) internal control standards issued by GAO, Joint Financial Management Improvement Program, and Commission on Accreditation for Law Enforcement Agencies, Inc.; and (2) audits conducted by the Department of Justice OIG, and Treasury IG for Tax Administration (TIGTA) of agencies' firearms controls.

- Document internal controls in agency policies and procedures to the maximum extent practical to help ensure that they are consistently understood and applied.

ACTIONS TAKEN:

- VA Police operations are inspected by the Office of Security and Law Enforcement (OS&LE) on a bi-annual basis to ensure compliance with all established policies and procedures. This inspection focuses on the firearm control as a key element in the inspection process. The areas of consideration include items such as: issuance of the firearms, turn in of firearms, control and oversight inspections on a regular and unannounced basis. If a discrepancy is noted during this inspection, the proper notifications are completed and an investigation is initiated.

- On a semi-annual basis, an outside agent (local property management staff) conducts an unannounced inspection of all firearms, magazines and rounds to ensure accountability of Department property. If a discrepancy is noted, notification is made and an investigation is initiated.

- A complete review of each policy regarding firearms is completed annually for each VA Police Service and reviewed on a bi-annual basis during the inspection process by OS&LE. Discrepancies are noted and revised. The policy is then

reviewed for consistency by OS&LE staff and a copy of each policy is maintained at OS&LE.

- Procedures for the reporting, investigation, and notification of all missing, lost, or stolen firearms or related equipment are in place. These procedures are included in each facility firearm policy.

BUDGET IMPLICATIONS:

- None. All items have been and are currently budgeted through the Office of Security and Law Enforcement, the local VA Medical Center VA Police, and the Office of Acquisition and Material Management's internal operating budgets.

5. VETERANS BENEFITS ADMINISTRATION: Process for Preventing Improper Payments to Deceased Veterans Can Be Improved (GAO-03-906), July 24, 2003

RESPONSIBLE ORGANIZATION: Veterans Benefits Administration (VBA)

RECOMMENDATIONS:

To improve the effectiveness of VBA's efforts to prevent improper payments to deceased veterans, GAO recommended that the Secretary of Veterans Affairs instruct the Under Secretary for Benefits to:

- Expand VBA's death match process beyond current disability program beneficiaries to include comparing its list of claimants against the individuals listed in Social Security Administration's (SSA's) master Death File.

- Review the 829 matched cases that were not included in GAO's assessment to: (1) determine whether and to what extent these beneficiaries received improper payments after having died, and (2) recover improper payments when appropriate.

- Issue guidance that restates the importance of following internal control procedures and acting on evidence that a beneficiary may have died to ensure that VBA's compensation and pension program staff are fully complying with the agency's internal control procedures.

ACTIONS TAKEN:

- Review of the 829 matched cases that were not included in GAO's assessment has been completed. Most cases did not appear to involve improper payments. Either the VA awards had been terminated or the VA awards were still running and Federal On Line Inquiry (FOLQ) indicated that the beneficiaries were alive in Social Security Administration (SSA) records. There were 21 cases where the stop dates in VA records appeared inconsistent with the date of death shown in SSA records. These have been referred to field stations for review. There were approximately 100 cases where there were active VA awards and the individuals appeared to be deceased in SSA records. More than half were already in a database of cases being considered for investigation by VA Office of Inspector General (OIG). An additional 39 cases were referred from VBA to OIG to consider for investigation.

- VBA did not agree with the recommendation to expand VBA's death match process beyond current disability program beneficiaries to include comparing its

list of claimants against the individuals listed in Social Security Administration's (SSA's) master Death File. Considerable resources would be required to include pending claims in the death match. We have never had a computer match involving the pending issue file. This would require a great deal of new programming and reprogramming. The most recent RCS 20-0207 report shows that more than 85 percent of all original pension claims are finalized in 6 months or less. Identifying the relatively few cases where a beneficiary dies while a claim is pending and the survivors do not return the initial check would not justify the expense of programming and maintaining a match against pending issue files.

- Fast Letter 03-43 dated November 26, 2003, restated the importance of following internal control procedures and acting on evidence that a beneficiary may have died to ensure that VBA's compensation and pension program staff are fully complying with the agency's internal control procedures.

BUDGET IMPLICATIONS:

- None

6. VETERANS BENEFITS: Improvements Needed in the Reporting and Use of Data on the Accuracy of Disability Claims Decisions (GAO-03-1045), September 30, 2003

RESPONSIBLE ORGANIZATION: Veterans Benefits Administration (VBA)

RECOMMENDATIONS:

GAO recommended that the Secretary of Veterans Affairs direct the Under Secretary for Benefits to:

- Report the accuracy of VBA disability compensation and pension claims decisions to the Congress and other stakeholders in a manner that allows for valid comparisons of accuracy across fiscal years.

- Better hold regional offices accountable for the accuracy of their claims decisions by increasing the use of its regional office accuracy data while, at the same time, maintaining an appropriate emphasis on production.

ACTIONS TAKEN:

- In our comments to the GAO Draft Report submitted September 24, 2003, we indicated our concurrence with both recommendations as outlined above. While we did identify in VA's Annual Performance and Accountability Report that our STAR reports had changed, described the nature of the change, and reported both the benefit entitlement and decision documentation/notification results, we did not recalculate prior reports using the new report criteria to facilitate trend analysis. Future quality assurance reports that include data from FY 1999 through 2001 will include both the original reported data and data for those years recalculated using the revised report criteria in order to facilitate comparisons across fiscal years.

- VBA will continue to increase accountability at the regional office level by requiring formal quality improvement plans from all offices failing to meet annual target levels for quality each fiscal year. Plans will be carefully reviewed and results closely monitored to confirm required improvement. For the FY 2004 performance award criteria, stations will have to meet both the rating and authorization quality in order to be eligible to receive FY 2004 performance awards.

- Quarterly regional office reports of completed corrective actions for every error identified by STAR reviews are now required. Site visit teams monitor the

information provided in these reports against claim folder reviews to validate report accuracy.

- Accuracy is a central focus of the FY 2004 resource allocation model. Area Directors will continue their oversight of all quality improvement efforts to increase accountability for performance.

BUDGET IMPLICATIONS:

- None